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# 2002 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2002)

#### IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 LCS 4/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 0044	024			II. CERTI	FICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: SAINT CLARE HOME  Address: 5533 N. GALENA ROAD  Number	PEORIA HEIGHTS City		61614 Zip Code	State of and cer	ve examined the contents of the accompanying report to the fillinois, for the period from 10/01/2001 to 09/30/2002 retiry to the best of my knowledge and belief that the said contents a accordance with
	County: PEORIA  Telephone Number: (309 ) 682-5428	Fax # ( )			applica	ble instructions. Declaration of preparer (other than provider) d on all information of which preparer has any knowledge.
	IDPA ID Number: 370813229001	,				ntional misrepresentation or falsification of any information cost report may be punishable by fine and/or imprisonment.
	Date of Initial License for Current Owners:	09/01/98			Officer or	(Signed)(Date)
	Type of Ownership:					(Type or Print Name) Pete Bolt III
	XX VOLUNTARY,NON-PROFIT	PROPRIETARY	GOV	ERNMENTAL	of Provider	(Title) Administrator
	XX Charitable Corp.	Individual		State		
	Trust	Partnership		County		(Signed)
	IRS Exemption Code	Corporation		Other		(Date)
		"Sub-S" Corp.			Paid	(Print Name CRAIG L. ATER
		Limited Liability Co. Trust			Preparer	and Title)
		Other				(Firm Name Heritage Enterprises
				-		& Address)
						(Telephone) ( 309 )823-7135 Fax # ( ) MAIL TO: OFFICE OF HEALTH FINANCE
	In the event there are further questions about th					ILLINOIS DEPARTMENT OF PUBLIC AID
	Name: CRAIG L. ATER	Telephone Number: ( )				201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Faci	lity Name & ID Numb	ber SAINT CLAI	ке номе				# 0044024 Report Period Beginning: 10/01/2001 Ending: 09/30/2002
	III. STATISTICA	AL DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/	certification level(s) of	f care; enter number	of beds/bed days,			403 (Do not include bed-hold days in Section B.)
	(must agree	with license). Date of	change in licensed b	eds			<u> </u>
	(		<b>g</b>	_		_	E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
	1				1		NONE
	Beds at				Licensed		NONE
		τ.		D I (F I e			ED alle de la
	Beginning of	Licensu		Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census? YES
	Report Period	Level of	Care	Report Period	Report Period		
							G. Do pages 3 & 4 include expenses for services or
1	60	Skilled (SNI		60	21,900	1	investments not directly related to patient care?
2		Skilled Pedi	atric (SNF/PED)			2	YES NO XX
3	34	Intermediat	e (ICF)	34	12,410	3	
4		Intermediat	e/DD			4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5	4	Sheltered Ca	are (SC)	4	1,460	5	YES NO XX
6		ICF/DD 16 o	or Less			6	
							I. On what date did you start providing long term care at this location?
7	98	TOTALS		98	35,770	7	Date started09/01/98
							J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	r the entire report per	riod.				YES xx Date 09/01/98 NO
	1	2	3	4	5		
	Level of Care	Patient Days	by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
		Public Aid					YES XX NO If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified and days of care provided 2,057
8	SNF	21,041	10,892	2,057	33,990	8	
9	SNF/PED			0		9	Medicare Intermediary Mutual of Omaha
10	ICF					10	•
11	ICF/DD					11	IV. ACCOUNTING BASIS
12	SC	0	0	0		12	MODIFIED
	DD 16 OR LESS	-				13	ACCRUAL XX CASH* CASH*
14	TOTALS	21,041	10,892	2,057	33,990	14	Is your fiscal year identical to your tax year? YES XX NO
		ccupancy. (Column 5,		tal licensed			Tax Year: Fiscal Year:
	bed days o	n line 7, column 4.)	95.02%	_			* All facilities other than governmental must report on the accrual basis.

Page 3

09/30/2002 SAINT CLARE HOME 0044024 **Report Period Beginning:** 10/01/2001 **Ending:** Facility Name & ID Number # V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

Costs Per General Ledger Reclass-Reclassified Adjusted FOR OHF USE ONLY Adjust-Salary/Wage **Operating Expenses** Supplies Other Total ification Total ments Total A. General Services 10 3 5 6 7 8 2 218,866 241,903 241,903 241,903 Dietary 23,037 1 1 Food Purchase 156,398 156,398 156,398 156,398 2 12,433 125,984 125,984 125,984 3 Housekeeping 113,551 3 48,591 48,591 Laundry 35,349 13,242 48,591 4 Heat and Other Utilities 94,834 94.834 94.834 94,834 5 62,359 48,232 32,173 142,764 142,764 142,764 6 Maintenance 6 Other (specify):\* 7 8 **TOTAL General Services** 430,125 253,342 127,007 810,474 810,474 810,474 B. Health Care and Programs Medical Director 3,600 3,600 3,600 3,600 9 Nursing and Medical Records 1,295,533 115,837 249,459 1,660,829 1,660,829 1,660,829 10 158,073 249,788 152,632 152,632 10a Therapy 91,715 (97,156)10a 355 60,252 60,252 60,252 11 Activities 55,855 4,042 11 12 Social Services 27,112 19 2,700 29,831 29,831 29,831 12 13 Nurse Aide Training 879 879 879 879 13 Program Transportation 14 15 Other (specify):\* 15 TOTAL Health Care and Programs 1,379,379 211,613 414,187 2,005,179 (97,156)1,908,023 1,908,023 16 C. General Administration Administrative 54,469 54,469 54,469 17 54,469 18 Directors Fees 18 269,740 268,503 19 Professional Services 269,740 269,740 (1,237)19 75,151 Dues, Fees, Subscriptions & Promotions 75,151 (51,465)23,686 (10.689)12,997 20 184,793 184,793 21 Clerical & General Office Expenses 154,974 15,059 14,760 184,793 21 445,280 445,280 445,280 22 Employee Benefits & Payroll Taxes 445,280 22 23 Inservice Training & Education 83 83 83 23 83 1,999 Travel and Seminar 10,268 10,268 24 24 10,268 (8,269)25 Other Admin. Staff Transportation 25 26 Insurance-Prop.Liab.Malpractice 7,289 7,289 7,289 7,289 26 (27,733)27 27 Other (specify):\* 27,733 27,733 27,733 TOTAL General Administration 209,443 15,059 850,304 1,074,806 (51,465)1,023,341 28 (47,928)975,413 TOTAL Operating Expense 2,018,947 480,014 1,391,498 3,890,459 (148,621)3,693,910 3,741,838 (47.928)29 (sum of lines 8, 16 & 28)

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

#0044024

**Report Period Beginning:** 

Page 4 10/01/2001 Ending: 09/30/2002

## V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHE	F USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			286,947	286,947		286,947		286,947			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,645	21,645		21,645	(19,509)	2,136			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,826	6,826		6,826	(4,747)	2,079			35
36	Other (specify):*											36
37	TOTAL Ownership			315,418	315,418		315,418	(24,256)	291,162			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					97,156	97,156		97,156			39
40	Barber and Beauty Shops		62	22,158	22,220		22,220		22,220			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					51,465	51,465		51,465			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		62	22,158	22,220	148,621	170,841		170,841			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,018,947	480,076	1,729,074	4,228,097		4,228,097	(72,184)	4,155,913			45

<sup>\*</sup>Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number SAINT CLARE HOME

# 0044024 Report Period Beginning:

10/01/2001

Ending:

Page 5 09/30/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	Tii Column	2 below, reference the	2	3	iai co:
		1	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES	Amount	ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,747)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(19,509)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties				18
19	Entertainment	(8,269)	24		19
20	Contributions	(248)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,237)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(27,485)	27		24
25	Fund Raising, Advertising and Promotional	(10,689)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
	Yellow Page Advertising				28
29			33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (72,184)		\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (72,184)		37

<sup>\*</sup>These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions)

(56	e instructions.)	1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Page 5A

SAINT CLARE HOME

| ID# | 0044024 | | Report Period Beginning: | 10/01/2001 | Ending: | 09/30/2002 |

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Summary A Facility Name & ID Number SAINT CLARE HOME 10/01/2001 Ending: 09/30/2002 # 0044024 Report Period Beginning:

	SUMMARY OF PAGES 5, 5A, 6, 6A	A, 6B, 6C, 6D, 6	E, 6F, 6G, 6H	I AND 6I									
													SUMMARY
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 <b>G</b>	6H	6I	(to Sch V, col.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0 2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0 8
	B. Health Care and Programs												
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0 10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0 13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0 16
	C. General Administration												
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	(1,237)	0	0	0	0	0	0	0	0	0	0	(1,237) 19
20	Fees, Subscriptions & Promotions	(10,689)	0	0	0	0	0	0	0	0	0	0	(10,689) 20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0 21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0 22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar	(8,269)	0	0	0	0	0	0	0	0	0	0	(8,269) 24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 26
27	Other (specify):*	(27,733)	0	0	0	0	0	0	0	0	0	0	(27,733) 27
28	TOTAL General Administration	(47,928)	0	0	0	0	0	0	0	0	0	0	(47,928) 28
	TOTAL Operating Expense												
29	(sum of lines 8,16 & 28)	(47,928)	0	0	0	0	0	0	0	0	0	0	(47,928) 29

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	TOTALS								
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 <b>G</b>	6H	<b>6</b> I	(to Sch V, col	.7)
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,509)	0	0	0	0	0	0	0	0	0	0	(19,509)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(4,747)	0	0	0	0	0	0	0	0	0	0	(4,747)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(24,256)	0	0	0	0	0	0	0	0	0	0	(24,256)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST		•											
45	(sum of lines 29, 37 & 44)	(72,184)	0	0	0	0	0	0	0	0	0	0	(72,184)	45

: 09/30/2002

#### VII. RELATED PARTIES

1. Enter below the hames of ALL owners and related organizations (parties) as defined in the mistractions. Attach an additional schedule if necessary	<ol> <li>Enter below the names of ALL owners and related org</li> </ol>	anizations (parties) as defined in the instructions. Attach an addition	onal schedule if necessary.
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		nated organizations (parties) as defined in the motivations. Attach an			- duditional conodato il nococcary.				
1	2			3					
OWNERS			RELATED NURSING HOME	ES		OTHER RELATED BUSINESS ENTITIES			
Name	Ownership %	Name		City		Name	City		Type of Business
				-					
				10.00					
				10.00					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
					Ü	Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V		<u> </u>						11
12	V								12
13	V		·						13
14	Total			s			\$	\$ *	14

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS Page 7
# 0044024 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report P

# VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home

must be listed on this schedule.

1 2 3 4 5 6 7

	1	2	3	4	5		6	7		8	
						Average Hou	ırs Per Work				
					Compensation		oted to this	Compensati	on Included	Schedule V.	
					Received	Facility and	% of Total	in Costs		Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

<sup>\*</sup> If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

<sup>\*\*</sup> This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.

ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS Page	OIS Page 8
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	Facility Name	& ID Number SAINT CLA	ARE HOME		#	0044024	Report Period Beginning:	10/01/2001	Ending:	9/30/2002	
	VIII. ALLOC	ATION OF INDIRECT COSTS									
A. Are there any costs included in this report which were derived from allocations of central office  Name of Related Organization  Street Address										-	
		nt organization costs? (See instru			onnee	;	City / State /			_	_
	or pare	int of gamization costs. (See instru	cuons.) 1 E5				Phone Numb		)		
	B. Show th	ne allocation of costs below. If ne	essary, please attach work	sheets.			Fax Number	(	)		
	1	2	3	4		5	6	7	8	9	
	Schedule V		Unit of Allocation		Nι	umber of	Total Indirect	Amount of Salary			
	T :		G . Dans Dissat Cost		CL.		Cart Dains	Cont Contained	E:1:4	A 11 a a a 4 i a a a	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•			\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12 13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

		STATE OF I	LLINOIS		Page 9
Facility Name & ID Number	SAINT CLARE HOME	# 0044024	Report Period Beginning:	10/01/2001 Ending:	09/30/2002

#### IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1 2 3 4 5 6 7

	1	2	•	3	4	5	6	7	8	9	10	
	Name of Lender	Relate YES	ed**	Purpose of Loan	Monthly Payment Required	Date of Note	Amoi Original	unt of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	OSF Health Care	XX		Working Capital							21,645	6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$ 21,645	9
	B. Non-Facility Related*											
10	Interest Income										(19,509)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (19,509)	14
15	TOTALS (line 9+line14)						\$	\$			\$ 2,136	15

16)	Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$ Line #	

<sup>\*</sup> Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

<sup>\*\*</sup> If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
# 0044024 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

Facility Name & ID Number SAINT CLARE HOME

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

b. Real Estate Taxes					
Real Estate Tax accrual used on 2001 report.	<i>Important</i> , please see the next worksheet, bill must accompany the cost report.	"RE_Tax". The real	estate tax statement and	s	1
			4-11 f1)		
2. Real Estate Taxes paid during the year: (Indicate the t	ax year to which this payment applies. If payment cover	ers more than one year, de	etali below.)	5	2
3. Under or (over) accrual (line 2 minus line 1).				s	3
4. Real Estate Tax accrual used for 2002 report. (Detail	and explain your calculation of this accrual on the lines	s below.)		s	4
5. Direct costs of an appeal of tax assessments which has (Describe appeal cost below. Attach copies	•			s	5
6. Subtract a refund of real estate taxes. You must offse classified as a real estate tax cost plus one-half of any TOTAL REFUND \$ For	, 11	al estate tax appeal	board's decision.)	s	6
7. Real Estate Tax expense reported on Schedule V, line	33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year: 1997	8		FOR OHF USE ONLY		
1998 1999	9 10	13	FROM R. E. TAX STATEMENT FO	OR 2001 \$	13
2000 2001	11 12	14	PLUS APPEAL COST FROM LINI	E 5 \$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CA	ALCULATION &	16

NOTES:

- 1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
  application for real estate tax exemption unless the building is rented from a for-profit entity.
  This denial must be no more than four years old at the time the cost report is filed.

#### IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

#### 2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME SAINT	CLARE HOME		COUNTY	PEORIA
FAC	ILITY IDPH LICENSE NU	JMBER 0044024			
CON	TACT PERSON REGARI	DING THIS REPORT			
TEL	EPHONE ( )	<del>-</del>	FAX #: (	)	
A.	Summary of Real Estate				
	cost that applies to the op-	eration of the nursing ho acant, rented to other org	me in Column D. Real es ganizations, or used for pu	tate tax applicable to rposes other than lor	nter only the portion of the o any portion of the nursing on term care must not be
	(A)		(B)	(C)	(D) Tax
	Tax Index Number	r <u>Prope</u>	rty Description	Total Tax	Applicable to Nursing Home
1.				\$	
3.				\$ \$	\$\$
4.				\$	\$
5.			_	\$	
6.				\$	\$
7.				\$	\$
8.				\$	
9.				\$	_ \$
10.				\$	
			TOTALS	\$	<u> </u>
B.	Real Estate Tax Cost Al	locations			
	Does any portion of the ta used for nursing home ser		n one nursing home, vacan YESNO		ty which is not directly
	If YES, attach an explana (Generally the real estate		shows the calculation of t		
C.	Tax Bills				

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Page 10A

STATE	UE II	TIN	MIC

224,000

Page 11

Facility Name & ID Number SAINT CLARE HOME 0044024 Report Period Beginning: 10/01/2001 Ending: 09/30/2002 X. BUILDING AND GENERAL INFORMATION: 33,800 **B.** General Construction Type: Brick/Wood **Number of Stories** Square Feet: Exterior Frame (c) Rent from Completely Unrelated Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. Organization. (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.) (c) Rent equipment from Completely Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.) List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable). YES NO Does this cost report reflect any organization or pre-operating costs which are being amortized? If so, please complete the following: 1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred: Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.) XI. OWNERSHIP COSTS: 2 3 Square Feet Year Acquired A. Land. Use Cost Land 224,000

3 TOTALS

# 0044024

Report Period Beginning:

Page 12 10/01/2001 Ending: 09/30/2002

Facility Name & ID Number SAINT CLARE HOME # 004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar.

	D. Dullul	ng Depreciation-Including Fixed Equ	uipinent. (See insti	ructions.) Koun	u an numbers to near	rest dollar.					
	1	TOD OVER 1/07 OVER 1/	2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	98				\$ 2,682,500	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Impro	vement Type**									
9	Smoke Detect			1999	1,932					T	9
10	Call Light Sys	tem		1999	16,785						10
11	Sewage Ejecto	or Pump		1999	3,800						11
	Door Alarm S			1999	1,275						12
13	Chapel Renov	ation		1999	1,760						13
14					,						14
15	Wallpaper/Pa	intRemodel Hallways		2000	45,058						15
16	Heat / Cool Pu	ımpRooftop A/C		2000	8,790						16
17	Corridor Ren	ovation		2000	19,472						17
18	Cubicle Curta	ins		2000	4,020						18
19	Flooring Ha	llways		2000	45,048						19
	Rooftop A/C U			2000	328,932						20
	Window Trea	tments		2000	7,221						21
	Sign			2000	720						22
	Chapel Renov			2000	32,210						23
24	Smoke Detect	ors		2000	3,300						24
25											25
		intRemodel Hallways		2001	8,820						26
	Door Alarm			2001	12,678						27
	Auto Door Op			2001	1,919						28
		overings North and West Wing Room		2001	73,863						29
		overings North and West Wing Room	sLabor	2001	3,750						30
	Rooftop A/C U			2001	88,341						31
	Flooring Ha	llways	•	2001	3,418						32
33											33
34											34
	Book Deprecia	ation				224,885		224,885		753,484	35
36		·									36

See Page 12A, Line 70 for total

<sup>\*</sup>Total beds on this schedule must agree with page 2.
\*\*Improvement type must be detailed in order for the cost report to be considered complete.

# 0044024

Report Period Beginning:

Page 12A 10/01/2001 Ending: 09/30/2002

Facility Name & ID Number SAINT CLARE HOME # 004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

B. Building Depreciation-Including Fixed Equipment. (See Instr	3	4	5	6	7	8	9	$\neg$
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
37 Security Alarm System	2002	s 15,826	\$		\$	\$	\$	37
38 Entry Doors	2002	22,435						38
39 Circulating Pump	2002	4,322						39
40 North Corridor Paint	2002	5,643						40
41 Wallpaper	2002	12,945						41
42 Window Treatments	2002	12,508						42
43								43
44								44
45								45
46								46 47
47 48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61 62
62 63								63
64								64
65								65
66								66
67						1		67
68								68
69								69
70 TOTAL (lines 4 thru 69)		s 3,469,291	\$ 224,885		\$ 224,885	\$	s 753,484	70

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SAINT CLARE HOME XI. OWNERSHIP COSTS (continued)

18

19

20 21

28

30

# 0044024

Report Period Beginning:

224,885

10/01/2001 Ending:

Page 12B 09/30/2002

18

19

20 21

27

28 29 30

31 32 33

34

753,484

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. Year **Current Book** Straight Line Accumulated Life Improvement Type\*\* Constructed Cost Depreciation in Years Depreciation Adjustments Depreciation 224,885 224,885 753,484 1 Totals from Page 12A, Carried Forward 3,469,291 3 2 3 4 5 6 7 4 5 6 7 8 9 10 10 11 11 12 13 14 12 13 14 15 16 17 15 16 17

3,469,291

224,885

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

STATE	OF I	LLIN	OIS

Page 13 SAINT CLARE HOME 0044024 **Report Period Beginning:** 10/01/2001 09/30/2002 Facility Name & ID Number **Ending:** 

#### XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	C. Equipment Depreciation-Excluding	dupment Depreciation-Excluding Transportation: (See instructions.)									
	Category of	1	1 Cu		rent Book Straight Line		Component	Accumulated			
	Equipment	Cost		Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6			
71	Purchased in Prior Years	\$ 470,536		\$ 62,062	\$ 62,062	\$		\$ 274,247	71		
72	Current Year Purchases	48,042							72		
73	Fully Depreciated Assets								73		
74			·						74		
75	TOTALS	\$ 518,578	·	\$ 62,062	\$ 62,062	\$		\$ 274,247	75		

D. Vehicle Depreciation (See instructions.)\*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

F Summary of Cara Polated Assats

	E. Summary of Care-Related Assets			<u></u>		
		Reference Am		Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	4,211,869	81	1
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	286,947	82	Ī
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	286,947	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$		84	Ī
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	1,027,731	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

Faci	lity Name & l	ID Number	SAINT CLARE HO	DME		# 0044024	Керс	ort Period Begi	nning: 10/01/2001	Ending:	09/30/200
XII.	1. Name of 2. Does the	and Fixed Equipm Party Holding Lea	nent (See instructions ase: eal estate taxes in add		ount shown below on		]NO				
		1	2	3	4	5	6				
		Year	Number	Date of	Rental	Total Years	Total Years				
		Constructed	of Beds	Lease	Amount	of Lease	Renewal Optio	n*			
١.	Original								10. Effective dates of curre		ment:
3	Building:			8				3	Beginning		
5	Additions							5	Ending		
6						-		6	11. Rent to be paid in futur	e vears under t	he current
7	TOTAL			s				7	rental agreement:	e years under t	ne current
	9. Option to B. Equipment 15. Is Move	ength of the lease o Buy: nt-Excluding Tran able equipment rer	YES sportation and Fixed tall included in build ble equipment:	NO Tern Equipment. (See ing rental?	ns:	*  YES pager, computer equip			12. /2003 13. /2004 14. /2005	\$ \$ \$	
						(Attach a schedu	le detailing the bro	eakdown of mo	vable equipment)		
	C. Vehicle R	Rental (See instruct		•		T .					
	1		2 Model Year	Ман	3 thly Lease	4 Rental Expense					
	Use	2	and Make		my Lease wment	for this Period	,		* If there is an option to	huv the buildi	ino.
17	Osc	-	and man	\$	.,	\$	17		please provide comple		
18							18		schedule.		
19							19				
20							20		** This amount plus any	amortization o	f lease
21	TOTAL			\$		\$	21		expense must agree w	ith page 4, line	34.

		S	TATE OF ILLI	NOIS					Page 15
Facility Name & ID Number SAINT CLARE HOM				#	0044024	Report Period Beginning:	10/01/2001	Ending:	09/30/2002
XIII. EXPENSES RELATING TO NURSE AIDE TRAINING  A. TYPE OF TRAINING PROGRAM (If aides are traine	,	,	schedule listing t	he facility n	ame, address	s and cost per aide trained in t	hat facility.)		
1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	YES 2.	CLASSROOM IN-HOUSE PR				3. <u>CLINICAL PO</u> IN-HOUSE PR	-		
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN OTHER FA COMMUNITY HOURS PER A	COLLEGE			IN OTHER FA			
B. EXPENSES	ALLOCATI	ON OF COSTS	(d)			C. CONTRACTUAL II		nount of in	ocome vour
	1 Fa	2 cility	3		4	facility received			
	Drop-outs	Completed	Contract		Total	S		1	
1 Community College Tuition	\$	\$	\$	\$				1	

879

879

879

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(a)

(b)

(c)

(e)

2 Books and Supplies

5 In-House Trainer Wages

SUM OF line 9, col. 1 and 2

3 Classroom Wages

4 Clinical Wages

6 Transportation
7 Contractual Payments
8 Nurse Aide Competency Tests

TOTALS

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

#### D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

879

879

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

#### XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
		Schedule V	Staff		Outside Practitioner		Supplies			
	Service	Line & Column	Units of	Cost	(other th	han consultant)	(Actual or)	Total Units	<b>Total Cost</b>	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	\$		\$ 56,272	\$		\$ 56,272	1
	Licensed Speech and Language									
2	Development Therapist	10a/3	hrs			25,136			25,136	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			71,224			71,224	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy	39/3	prescrpts				91,715		91,715	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): x-ray	39/3				5,441			5,441	13
14	TOTAL			\$		\$ 158,073	\$ 91,715		\$ 249,788	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

# 0044024 Report Period Beginning: 10/01/2001
As of 09/30/2002 (last day of reporting year)

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/2:

This report must be completed even if financial statements are attached.

		1		2 After	
		C	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	455,329	\$	1
2	Cash-Patient Deposits		2,970		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance		514,270		3
4	Supply Inventory (priced at )				4
5	Short-Term Investments				5
6	Prepaid Insurance		31,540		6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	1,004,109	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		224,000		13
14	Buildings, at Historical Cost		3,466,969		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		529,324		16
17	Accumulated Depreciation (book methods)		(1,027,731)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify):				23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	3,192,562	\$	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	4,196,671	\$	25

			1		2 After	I
			_	perating	Consolidation*	
		C. Current Liabilities	Ť	p.vg		
	26	Accounts Payable	\$	82,012	\$	26
	27	Officer's Accounts Payable				27
	28	Accounts Payable-Patient Deposits		2,970		28
1	29	Short-Term Notes Payable				29
3	30	Accrued Salaries Payable		191,459		30
		Accrued Taxes Payable				
1	31	(excluding real estate taxes)		(18)		31
-	32	Accrued Real Estate Taxes(Sch.IX-B)				32
3	33	Accrued Interest Payable				33
	34	Deferred Compensation				34
3	35	Federal and State Income Taxes				35
		Other Current Liabilities(specify):				
	36					36
	37					37
		TOTAL Current Liabilities				
3	38	(sum of lines 26 thru 37)	\$	276,423	\$	38
		D. Long-Term Liabilities				
	39	Long-Term Notes Payable				39
	40	Mortgage Payable				40
	41	Bonds Payable				41
_ 4	42	Deferred Compensation				42
		Other Long-Term Liabilities(specify):				1 12
	43					43
	44					44
		TOTAL Long-Term Liabilities				1
Ľ	45	(sum of lines 39 thru 44)	\$		\$	45
		TOTAL LIABILITIES				
	46	(sum of lines 38 and 45)	\$	276,423	\$	46
١.	<b>1</b> 7	TOTAL FOURTV(mage 10 Kms 24)	\$	2 020 249	6	47
Ľ	+/	TOTAL EQUITY(page 18, line 24) TOTAL LIABILITIES AND EQUITY		3,920,248	\$	4/
4	48	(sum of lines 46 and 47)	\$	4,196,671	\$	48
						•

Page 17 09/30/2002

**Ending:** 

<sup>\*(</sup>See instructions.)

JF CF	HANGES IN EQUITY			
			1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	4,213,509	1
2	Restatements (describe):			2
3				3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	4,213,509	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		(293,261)	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	(	)	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	(293,261)	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	3,920,248	24

<sup>\*</sup> This must agree with page 17, line 47.

# 0044024 XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 4,106,014	1
2	Discounts and Allowances for all Levels	(711,219)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,394,795	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	334,619	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 334,619	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	30,578	12
13	Barber and Beauty Care	23,309	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	127,507	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,677	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 185,071	23
	D. Non-Operating Revenue		
24	Contributions	842	24
25	Interest and Other Investment Income***	19,509	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20,351	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,934,836	30

		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	810,474	31
32	Health Care	2,005,179	32
33	General Administration	1,074,806	33
	B. Capital Expense		
34	Ownership	315,418	34
	C. Ancillary Expense		
35	Special Cost Centers	22,220	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,228,097	40
41	Income before Income Taxes (line 30 minus line 40)**	(293,261)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (293,261)	43

*	This must	t agree with	page 4,	line 45,	column 4.
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*	Does this agree wit	h taxable income (loss) per Federal Income
	Tax Return?	If not, please attach a reconciliation.

See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

<sup>\*\*\*\*</sup>Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number SAINT CLARE HOME

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	1,992	2,080	\$ 48,040	\$ 23.10	1
2	Assistant Director of Nursing	2,306	2,491	49,992	20.07	2
3	Registered Nurses	8,351	8,940	178,503	19.97	3
4	Licensed Practical Nurses	17,919	20,381	324,694	15.93	4
5	Nurse Aides & Orderlies	56,592	61,948	643,239	10.38	5
6	Nurse Aide Trainees	100	100	879	8.79	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,392	3,973	51,065	12.85	8
9	Activity Director					9
10	Activity Assistants	5,341	6,169	55,855	9.05	10
11	Social Service Workers	2,224	2,310	27,112	11.74	11
	Dietician					12
	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,082	21,845	218,866	10.02	15
16	Dishwashers					16
17	Maintenance Workers	4,218	4,436	62,359	14.06	17
	Housekeepers	11,655	13,162	113,551	8.63	18
19	Laundry	3,348	3,861	35,349	9.16	19
20	Administrator	2,080	2,080	54,469	26.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,235	12,003	154,974	12.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
	Qualified MR Prof. (QMRP)					28
	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	150,835	165,779	\$ 2,018,947 *	s 12.18	34

<sup>\*</sup> This total must agree with page 4, column 1, line 45.

#### B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		s 0		35
36	Medical Director		3,600		36
37	Medical Records Consultant		375		37
38	Nurse Consultant				38
39	Pharmacist Consultant		550		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,475		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 7,000		49

### C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$ 36,873		50
51	Licensed Practical Nurses		97,089		51
52	Nurse Aides		110,667		52
53	TOTAL (lines 50 - 52)		\$ 244,629		53
	•				

<sup>\*\*</sup> See instructions.

STATE OF ILLINOIS P	age 21
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	SAINT CLARE HO	OME			#_ 004	14024	Repo	ort Period Begi	nning:	0/01/2001 End	ing:	09/30/2002
XIX. SUPPORT SCHEDULES					ID E I D C.	D. H.T.			I E B E	6.1		
A. Administrative Salaries	E	Ownershi	ip		D. Employee Benefits and	Payroll Taxes				s, Subscriptions and Prom	otions	
Name	Function	%	•	Amount		ription	•	Amount		Description		Amount
Pete Bolt	Administrator		_ \$_	54,469	Workers' Compensation 1		\$_	12,441	IDPH Licens		\$_	0
					Unemployment Compens	ation Insurance	_	(4,614)	Advertising:	Employee Recruitment		4,980
					FICA Taxes		_	154,449		Worker Background Che		
					Employee Health Insuran	ce	_	219,121	_	f checks performed 25	) _	224
					Employee Meals		_		Central Office			
					Illinois Municipal Retiren		_		Promotional			6,121
					Employee Hepatitis Vaccin	1e	_	0	Public Relati			4,568
TOTAL (agree to Schedule V, line					Employee Benefits -		_	63,883	<b>Dues and Sul</b>			7,164
(List each licensed administrator s	separately.)		\$	54,469	<b>Employee Benefits - centra</b>	al office	_		License and	Fees		629
B. Administrative - Other							_					
									Less: Publi	c Relations Expense		(4,568)
Description				Amount					Non-a	llowable advertising	_ ( -	0
			\$						Yellov	v page advertising		(6,121)
							_	<u> </u>				
					TOTAL (agree to Schedu	ile V,	\$	445,280	-	TOTAL (agree to Sch. V,	\$	12,997
					line 22, col.8)		_			line 20, col. 8)	=	
TOTAL (agree to Schedule V, line	17, col. 3)		\$		E. Schedule of Non-Cash	Compensation Paid			G. Schedule	of Travel and Seminar**		
(Attach a copy of any managemen	t service agreement	t)	-		to Owners or Employe	es						
C. Professional Services		,			1				1	Description		Amount
Vendor/Pavee	Type			Amount	Description	Line #		Amount		F		
Heritage Enterprises	Management Fe	ees	\$	237,435			\$		Out-of-State	Travel	\$	
OSF Health System	Accounting			21,288		<del></del>	_	<del></del>				
Morehead Associates	Benefit Consult	inσ		2,827			-					
OSF Health System	Audit Fees			4,000			-		In-State Tra	vel		
OSF Health System	Pastoral Care			2,782			_		In State III	102		3,137
NJ Interior	Interior Consul	+		171			-					0,107
THE THE TOT	Interior Consul			1/1			_	<u></u>				<u> </u>
				0			_		Seminar Exp	nonco		7,131
				<u> </u>			_		Non Allowab			(8,269)
Hartweg Mueller & Turner	Logal			1,237			_		Central Office			(0,209)
	Legal						_		Central Offic	e Anocation		
Legal Fees (Adjusted to zero)				0			_		P	4.E	_ , -	
TOTAL (among to Calculate V. P.	10			0	TOTAL		e.		Entertainme		_ ( _	
TOTAL (agree to Schedule V, line (If total legal fees exceed \$2500 att	,			269,740	TOTAL		\$_		TOTAL	(agree to Sch. V, line 24, col. 8)		1,999
			S								\$	

Page 22 09/30/2002 Report Period Beginning: 10/01/2001 **Ending:** 

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	tized Per Year			
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility	y Name & ID Number SAINT CLARE HOME	#	0044024	Report Period Beginning:	10/01/2001	Ending:	09/30/2002
XX. G	ENERAL INFORMATION:						
(1)	Are nursing employees (RN,LPN,NA) represented by a union?	(13)		upplies and services which are of the Public Aid, in addition to the daily in			
(2)	Are there any dues to nursing home associations included on the cost report?  If YES, give association name and amount. Illinois Healthcare Association			etion of Schedule V? yes	_	•	
(3)	Did the nursing home make political contributions or payments to a political action organization?   no If YES, have these costs been properly adjusted out of the cost report?   yes	(14)	the patient census l is a portion of the b	ouilding used for any function other isted on page 2, Section B? no ouilding used for rental, a pharmacy explains how all related costs were a	, day care, etc.)	For example If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?	` /	Indicate the cost of on Schedule V. related costs?		assified to employ meal income be the amount. \$	een offset ag	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases?  What was the average life used for new equipment added during this period?  yes  7 years	(16)	Travel and Transpo	ortation neluded for out-of-state travel?	no		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10		If YES, attach a	complete explanation.  Eparate contract with the Departmen	nt to provide me		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.		program during to. What percent of	his reporting period. \$ all travel expense relates to transporting logs been maintained? yes			
(8)	Are you presently operating under a sale and leaseback arrangement? no If YES, give effective date of lease.		e. Are all vehicles s times when not i	stored at the nursing home during th			
(9)	Are you presently operating under a sublease agreement? YES xx NO		out of the cost re	port? yes	J.		
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO no If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.		Indicate the a	ty transport residents to and fr nount of income earned from p during this reporting period.		n Ö	no
		(17)		performed by an independent certific	ed public accour	nting firm? The instruct	
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 51,465  This amount is to be recorded on line 42 of Schedule V.		cost report require been attached?	that a copy of this audit be included No If no, please explain.	with the cost re		
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  no If YES, attach an explanation of the allocation.	(18)	Have all costs which out of Schedule V?	th do not relate to the provision of lo	ong term care be	en adjusted o	out
		(19)	performed been att	e in excess of \$2500, have legal invached to this cost report?  d a summary of services for all arch		,	ices

Page 23

Table	=	Basinia PUTO CASE CHIEFERAN	GS. Balance alti(De		ng 1864 i pg 14daman Liar d Aman Lian	46,00 01,70		
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Column	346 346	COMMON PORTON LEDGE			3,00			
Column	230 230	COMMON COOK	4701 me		100	471700		
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The content of the	=	AND WHEN THE ADDRESS OF THE ADDRESS	21,000	- 1			CONTRACTOR	10,3
The content of the		LPS WHOSE MEDICALS	361,365	- 1	111		ON CHARGOS	- 3
The control of the	100	LPS WALLS STORM	21,400				On Chicagost	
The content of the	cos cos	MARCHINE	843,69				On CHARGE	- 3
The continues of the	GE GE	CONTRACT SERVICES	350				Gas Canadonia	100
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The content of the	## ##	NAME AND TRANSPORT OF		1.3	111		000 000 BY TANK	104
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The content of the	130	NUMBER OFFICE AND ADDRESS OF THE PERSON	3,965 (1,694	100,000 10 90,515 10	1 1 1		600 COLUMN NA	10.0
1	100	DRICK PORCHASTACIONS LABORATORY STRVETS	1016	1900 19	1 : :		NAME AND ADDRESS OF	- 63
1	140	BOAR HEALTH GOLD VAC BOAR HEALTH GODGE		- 1			the character	
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1	20	TOX COMES SERVERS		. 1			50 50 50 50 50 50	
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**************************************	0000	ENCROPT CHES					100 100 800 800	-0.5
	GLOSS T	DALANCE SELECTIONS						
94. ************************************	GLOUD I	BALANCE SEET TOTAL	201,34				-	
34,000 Majori 200 ARTONIA 120 Majori 201 ARTONIA 120	CALCOUNT	PACKETY CHEST.	anai er	BICAP CONTO			-	263
— A MERITANISM CAN DESCRIPTION OF THE PROPERTY	GLOSE T	PACKETY TOTAL	241,341 GL 11,841 21,121 2,847	BREAP-CROSES 11,613 24,001 1,607			-	26,3
	CRANCE T	PACKETY DODGE.  BALLOCK SHET DODGE.  PP  PA  Religion	201,361 51,001 21,001 2,001 3,001 14,000	BBE AP CENSES 11,001 20,001 3,000 14,000			=	26,3
	CRAWEST	PACKETY CHIPS  BALANCE SHEET TOTAL  PP  PA  INSIDER  PACKETHELE  PP CONVENTS  PP CONVENTS	241,361 GL 31,351 3,401 34,361 34,361 131 6	88749-CHORD 1940 1950 1960 1960 1960			32	26,3